STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155730	A. BUILDING 01 B. WING	06/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
RIPLEY CROSSING	1200 WHITLATCH WAY MILAN, IN47031

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/15/11 Facility Number: 000420 Provider Number: 155730 AIM Number: 100266230 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Ripley Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies, NFPA 101, Life Safety Code (LSC) and 410 IAC 16.2. The original building was surveyed with Chapter 19, Existing Health Care Occupancies. This one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a two hour separation from Wing 5 labeled as the	K0000	K00 The filing of this plan of correction does not constitute an admission that the alleged deficiency did in fact exist. This plan of correction if filed as evidence of the facilities desire to comply with the regulation will continuing to provide quality of care to all residents.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	Rehabilitation Wing to the northwest of the original building and a two hour separation from Wing 4 to the Residential Wing to the southeast of the original building. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident sleeping rooms. The facility has a capacity of 100 and had a census of 95 at the time of this visit. Quality Review by Robert Booher, REHS, Life Safety Code Specialist-Medical Surveyor on 06/16/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following			
K0025 SS=E	Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4 Based on observations and interview, the facility failed to ensure 1 of 71 room's ceiling smoke barriers in the original building was constructed to provide at least a one half hour fire resistance rating. This deficient practice could affect any	K0025	K025 1.What corrective action will be accomplished: Replacement of the fire caulk and 2 metal flanges were screwed in to close all gaps around the duct. 2. How other residents have the potential to be effected: All residents have	06/30/2011

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	resident using the main dining room, which is located adjacent to the laundry room. Findings include: Based on observation with the maintenance supervisor on 06/15/11 at 1:50 p.m., the laundry room dust collection room located behind the dryers had two duct penetrations through the ceiling with two inch to four inch gaps around the duct penetrations which was not firestopped. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)		the potential to be effected. 3. What measures/changes have been put in place: Maintenance supervisor will monitor the area every day x 2 weeks, then during his rounds. 4. How this corrective action will be monitored: Administrator or designee will monitor to ensure the measures are being completed. 5. What date these changes will be completed: June 30, 2011	
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to provide a fire alarm system trouble signal in a location likely to be heard by facility staff in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and	K0052	K52 1.What corrective action will be accomplished: The automatic dialer box was replaced. 2. How other residents have the potential to be effected: All residents have the potential to be effected. 3. What measures/changes have been put in place: The automatic dialer will be checked 3 times per week times 1 month then	06/30/2011

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	trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation and fire alarm testing with the maintenance supervisor on 06/15/11 at 3:30 p.m., when the automatic dialer component was placed in trouble from phone line failure for twenty five minutes, the local trouble signal was not initiated at the digital dialer box located in the front entrance which was not continually occupied by facility staff, or at the fire alarm system subpanel located at the Wing 4 nurses' station. Based on an interview with the maintenance supervisor on 06/15/11 at 3:50 p.m., the fire alarm system had an electrical problem a few months ago and the fire alarm system contractor disconnected the trouble signal from the main panel then did not reconnect the electrical wiring. Based on observation of the fire alarm system electrical panel with the maintenance supervisor on 06/15/11 at 3:55 p.m., the electrical wiring feeding the trouble signal was visibly disconnected. 3.1-19(b)		monthly. 4. How this corrective action will be monitored: Administrator or designee will monitor monthly. 5. What date these changes will be completed: June 30, 2011	

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	Based on observation and interview, the facility failed to provide a fire alarm system trouble signal in a location likely to be heard by facility staff in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors. Findings include: Based on an observation and fire alarm testing with the maintenance supervisor on 06/15/11 at 3:30 p.m., when the automatic dialer component was placed in trouble from phone line failure for twenty five minutes, the local trouble signal was not initiated at the digital dialer box located in the front entrance which was not continually occupied by facility staff, or at the fire alarm system subpanel located at the Wing 4 nurses' station. Based on an interview with the maintenance supervisor on 06/15/11 at 3:50 p.m., the fire alarm system had an electrical problem a few months ago and the fire alarm system contractor disconnected the trouble signal from the main panel then did not reconnect the	K0052	K52 1.What corrective action will be accomplished: The automatic dialer box was replaced. 2. How other residents have the potential to be effected: All residents have the potential to be effected. 3. What measures/changes have been put in place: The automatic dialer will be checked 3 times per week times 1 month then monthly. 4. How this corrective action will be monitored: Administrator or designee will monitor monthly. 5. What date these changes will be completed: June 30, 2011	06/30/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	electrical wiring. Based on observation of the fire alarm system electrical panel with the maintenance supervisor on 06/15/11 at 3:55 p.m., the electrical wiring feeding the trouble signal was visibly disconnected. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine	K0144	K144 1. What correction action will be accomplished: The load bank test will becompleted at least every year.This generator does not require a remote manual stopdue to its size, (see attached, letter). 2. How other residents havethe potential to be effected:All residents have the potentialto be effected. 3. What measures/changes have been put in place:The load bank test will be preformed annually duringscheduled semi annual visits. 4. How this corrective actionwill be monitored:Administrator or designeewill monitor. 5. Completion date:July 11, 2011	07/11/2011

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	at the engine and from a remote location. This deficient practice could affect all residents. Findings include: Based on observation of the emergency generator set and a tour of the facility with the maintenance supervisor on 06/15/11 from 12:10 p.m. to 4:05 p.m., there was no emergency stop switch located outside the emergency generator set building, or in the facility. The emergency generator set was a six cylinder diesel and lacked a listing of the horsepower on the nameplate on the side of the engine. Based on an interview with the maintenance supervisor on 06/15/11 at 3:45 p.m., the diesel generator is over one hundred horsepower. 3-1.19(b) 2. Based on record review and interview, the facility failed to ensure the load testing for the past 12 months was conducted under operating conditions or not less than 30 percent of the nameplate rating for the emergency generator set to protect 95 of 95 residents. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the			

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	emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by the authority having jurisdiction. This deficient practice affect all residents in the facility. Findings include: Based on a review of the Generator Testing Log Book on 06/15/11 at 3:00 p.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes but did not indicate a thirty percent rated test was conducted during each load test. The Generator Testing Log Book listed the voltage and hertz during each test. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)			
K0000	A Life Safety Code Recertification and	K0000	K00 The filing of this plan of correction does not constitute an	

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	State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 06/15/11 Facility Number: 000420 Provider Number: 155730 AIM Number: 100266230 Surveyor: Mark Bugni, Life Safety Code Specialist At this Life Safety Code survey, Ripley Crossing was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies, NFPA 101, Life Safety Code (LSC) and 410 IAC 16.2. The 2007 Wing 5 Rehabilitation Wing was surveyed with Chapter 18, New Health Care Occupancies. The 2007 Wing 5 Rehabilitation Wing addition to the one story facility was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, spaces open to the corridors, and all resident		admission that the alleged deficiency did in fact exist. This plan of correction if filed as evidence of the facilities desire to comply with the regulation will continuing to provide quality of care to all residents.	

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	sleeping rooms. The facility has a capacity of 100 and had a census of 95 at the time of this survey. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following			
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure 1 of 2 exit accesses in the Wing 5 Rehabilitation Wing supplied with a delayed egress lock was provided with a sign indicating, PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. LSC 7.2.1.6.1, requires approved, listed, delayed-egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected throughout by an approved, supervised automatic fire detection system in accordance with Section 9.6, or an approved, supervised automatic sprinkler system in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided the following criteria are met: (a) The doors shall unlock upon actuation of an approved, supervised automatic sprinkler system in accordance with Section 9.7 or upon the actuation of any heat detector or activation of not more than two smoke	K0038	K038 1. What corrective action will be accomplished: A sign was placed on the door, “push until alarm sounds, door can be opened in 30 seconds.” 2. How other residents have the potential to be effected: All residents have the potential to be effected. 3. What measures/changes have been put in place: Maintenance supervisor will monitor during his rounds to ensure the sign stays in tack. 4. How this corrective action will be monitored:Administrator or designee willmonitor. 5. What date these changes willbe completed:June 30, 2011	06/30/2011

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	detectors of an approved, supervised automatic fire detection system in accordance with Section 9.6. (b) The doors shall unlock upon loss of power controlling the lock or locking mechanism. (c) An irreversible process shall release the lock within 15 seconds upon application of a force to the release device required in 7.2.1.5.4 that shall not be required to exceed 15 lf nor be required to be continuously applied for more than 3 seconds. The initiation of the release process shall activate an audible signal in the vicinity of the door. Once the door lock has been released by the application of force to the releasing device, relocking shall be by manual means only. Exception: Where approved by the authority having jurisdiction, a delay no exceeding 30 seconds shall be permitted. (d) On the door adjacent to the releasing device, there shall be a readily visible, durable sign in letters not less than 1 inch high and not less than 1/8 inch in stroke width on a contrasting background that reads as follows: PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This deficient practice affects 18 residents who reside on the Wing 5 Rehabilitation Wing. Findings include:			

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	Based on observations on 06/15/11 at 3:30 p.m. with maintenance supervisor, the Wing 5 Reanimation Wing end hall northwest exit was equipped with a delayed egress lock. Furthermore, the Wing 5 Rehabilitation Hall exit door was not provided with a sign indicating PUSH UNTIL ALARM SOUNDS DOOR CAN BE OPENED IN 15 SECONDS. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)			
K0044 SS=E	Horizontal exits, if used, are in accordance with 7.2.4. 18.2.2.5 Based on observation and interview, the facility failed to ensure 1 of 1 fire doors was arranged to latch. LSC 7.2.4.3.8 requires fire barrier doors to be self closing or automatic closing in accordance with 7.2.1.8. NFPA 80, the Standard for fire Doors and Fire Windows at 2-4.1.4 requires all closing mechanisms shall be adjusted to overcome the resistance of the latch mechanism so positive latching is achieved on each door operation. This deficient practice could affect 18 residents who reside on the Wing 5 Reanimation Wing.	K0044	K44 1.What corrective actions will be accomplished: The hinges on the doors were adjusted to allow positive latching. 2. How other residents have the potential to be effected: All residents have the potential to be effected. 3. What measures/changes have been put in place: Maintenance supervisor will monitor the doors daily x 1 week, then weekly x 1 monthly, then monthly. 4. How this corrective action will be monitored: Administrator/designee will monitor monthly. 5. What date these changes will be completed: June 30, 2011	06/30/2011

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	Findings include: Based on observation on 06/15/11 with the maintenance supervisor, the Wing 5 Rehabilitation Wing set of one and one half hour fire doors was manually closed and failed to latch on three attempts at the 2:10 p.m. tour of the facility, and failed to latch during the fire alarm system test conducted at 3:30 p.m. This was verified by the maintenance supervisor at the time of observations. 3.1-19(b)			
K0052 SS=F	A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on observation and interview, the facility failed to provide a fire alarm system trouble signal in a location likely to be heard by facility staff in accordance with NFPA 72, National Fire Alarm Code. NFPA 72, 1-5.4.6 requires trouble signals to be located in an area where it is likely to be heard. NFPA 72, 1-5.4.4 requires fire alarms, supervisory signals, and trouble signals to be distinctive and descriptively annunciated. This deficient practice could affect all residents, staff and visitors.	K0052	K52 1.What corrective action will be accomplished: The automatic dialer box was replaced. 2. How other residents have the potential to be effected: All residents have the potential to be effected. 3. What measures/changes have been put in place: The automatic dialer will be checked 3 times per week times 1 month then monthly. 4. How this corrective action will be monitored: Administrator or designee will monitor monthly. 5. What date these changes will be	06/30/2011

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			completed: June 30, 2011	
	Findings include: Based on an observation and fire alarm testing with the maintenance supervisor on 06/15/11 at 3:30 p.m., when the automatic dialer component was placed in trouble from phone line failure for twenty five minutes, the local trouble signal was not initiated at the digital dialer box located in the front entrance which was not continually occupied by facility staff, or at the fire alarm system subpanel located at the Wing 4 nurses' station. Based on an interview with the maintenance supervisor on 06/15/11 at 3:50 p.m., the fire alarm system had an electrical problem a few months ago and the fire alarm system contractor disconnected the trouble signal from the main panel then did not reconnect the electrical wiring. Based on observation of the fire alarm system electrical panel with the maintenance supervisor on 06/15/11 at 3:55 p.m., the electrical wiring feeding the trouble signal was visibly disconnected. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. 1. Based on observation and interview, the facility failed to ensure 1	K0144	K144 1. What correction action will be accomplished: The load	07/11/2011

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	of 1 emergency generators was equipped with a remote manual stop. LSC 7.9.2.3 requires emergency generators providing power to emergency lighting systems shall be installed, tested and maintained in accordance with NFPA 110, Standard for Emergency and Standby Power Systems. NFPA 110, 1999 edition, 3-5.5.6 requires Level I installations shall have a remote manual stop station of a type similar to a break-glass station located outside the room housing the prime mover. NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, 1998 Edition, at 8-2.2(c) requires engines of 100 horsepower or more have provision for shutting down the engine at the engine and from a remote location. This deficient practice could affect 18 residents who reside on the Wing 5 Reanimation Wing. Findings include: Based on observation of the emergency generator set and a tour of the facility with the maintenance supervisor on 06/15/11 from 12:10 p.m. to 4:05 p.m., there was no emergency stop switch located outside the emergency generator set building, or in the facility. The		bank test will becompleted at least every year.This generator does not require a remote manual stopdue to its size, (see attached, letter). 2. How other residents havethe potential to be effected:All residents have the potentialto be effected. 3. What measures/changes have been put in place:The load bank test will be preformed annually duringscheduled semi annual visits. 4. How this corrective actionwill be monitored:Administrator or designeewill monitor. 5. Completion date:July 11, 2011	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155730	A. BUILDING 02 B. WING	06/15/2011

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	emergency generator set was a six cylinder diesel and lacked a listing of the horsepower on the nameplate on the side of the engine. Based on an interview with the maintenance supervisor on 06/15/11 at 3:45 p.m., the diesel generator is over one hundred horsepower. 3-1.19(b) 2. Based on record review and interview, the facility failed to ensure the load testing for the past 12 months was conducted under operating conditions or not less than 30 percent of the nameplate rating for the emergency generator set to protect 95 of 95 residents. Chapter 3-4.4.1.1 of NFPA 99 requires monthly testing of the generator serving the emergency electrical system to be in accordance with NFPA 110, the Standard for Emergency and Standby Powers Systems, chapter 6-4.2. Chapter 6-4.2 of NFPA 110 requires generator sets in Level 1 and Level 2 service to be exercised under operating conditions or not less than 30 percent of the EPS nameplate rating at least monthly, for a minimum of 30 minutes. Chapter 3-5.4.2 of NFPA 99 requires a written record of inspection, performance, exercising period, and repairs for the generator to be regularly maintained and available for inspection by			

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	the authority having jurisdiction. This deficient practice could affect 18 residents who reside on Wing 5 Realization Wing. Findings include: Based on a review of the Generator Testing Log Book on 06/15/11 at 3:00 p.m. with the maintenance supervisor, the Generator Testing Log Book showed a monthly load test for each of the past twelve months for thirty minutes but did not indicate a thirty percent rated test was conducted during each load test. The Generator Testing Log Book listed the voltage and hertz during each test. This was verified by the maintenance supervisor at the time of observation. 3.1-19(b)			